TCHP – MEDICAL BENEFITS SUMMARY

Plan Year Maximums and Deductibles

The benefits described in this summary represent the major areas of coverage under TCHP. Updated information for each plan year will appear in the annual Benefit Choice Options Booklet. The plan year is July 1 through June 30 of the following year.	
Lifetime Maximum	$2 million
Plan Year Deductible	The plan year deductible is $250 for each covered person.
Special Deductibles* ***These are in addition to the plan year deductible.**	Each emergency room visit $250 Non-PPO hospital admission $250 Transplant deductible $100 Note: There is no special deductible for admission to a PPO hospital

Out-of-Pocket Maximums

There are two separate out-of-pocket maximums: a general and a non-PPO. Coinsurance and deductibles listed below count toward one or the other, but not toward both.

General: $800 per individual	**Non-PPO: $4,000 per individual**
Plan year deductible Professional and Physician Coinsurance PPO Facility Coinsurance (20%) Transplant Deductible ($100) Transplant Inpatient and Outpatient Coinsurance (20%) Standard* Hospital Coinsurance (30%) Standard* Hospital Admission Deductible ($250) All Emergency Room Deductibles ($250) Emergency Room Coinsurance (20%) ***When the Notification Administrator grants an exception for a non-PPO admission, or when the plan participant does not reside within 25 miles of a TCHP PPO hospital.**	Non-PPO Hospital Deductible ($250) Non-PPO Inpatient Coinsurance (40%) Non-PPO Outpatient Facility Coinsurance (40%)

The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits or copayments.
- Mental Health/Substance Abuse benefits, coinsurance or copayments.
- Notification penalties.
- Ineligible charges (amounts over U&C and charges for non-covered services).
- The portion ($50) of the Medicare Part A deductible the plan participant is responsible to pay.

Most Commonly Utilized Benefits Under TCHP

Enhanced benefits may be available by utilizing PPO network providers.

Allergy Injections

- 80% of U&C for injections, provided the person has had recognized allergy testing to determine hypersensitivity and the need to be desensitized.
- Allergy testing is paid at 100% of U&C.

Ambulance

- 80% of U&C for transportation charges:
  - To nearest hospital/facility for emergency medically necessary services for a patient whose condition (as determined by the Medical Plan Administrator) warrants such service.
- Common Reasons for Transportation Services:
  - From the site of the disabling illness, injury, accident or trauma to the nearest hospital qualified to provide treatment (includes air ambulance when medically necessary).
  - From a remote area, by air or land, (inside or outside the United States) to the nearest hospital qualified to provide emergency medical treatment.
  - From a facility which is not equipped to treat the patient's specific injury, trauma or illness to the nearest hospital equipped to treat the injury, trauma or illness.
- Transportation exclusions include, but are not limited to:
  - Transportation that is not medically necessary.
  - Transportation between health care facilities for preference or convenience.
  - Transportation of patient for office or other outpatient visit.
  - Transportation of patients who have no other available means of transportation.

Blood/Blood Plasma

- 80% of charges for blood and blood plasma in excess of the first 3 pints in a plan year.

Breast Implantation Removal and Reimplantation

- Coverage for removal or implantation only when medically necessary and not cosmetic in nature.
- Coverage for reimplantation only when initial implant was medically necessary.

Breast Reconstruction Following Mastectomy

- The Plan provides coverage, subject to and consistent with all other plan provisions for services following a mastectomy, including:
  - Reconstruction of the breast (including implant) on which the mastectomy was performed.
  - Surgery and reconstruction on the other breast (including implants) to produce a symmetrical appearance.
  - Prosthesis and treatment for any physical complications at any stage of mastectomy, including post-surgical lymphedema (swelling associated with the removal of lymph nodes) rendered by a provider covered under the Plan.

Cardiac Rehabilitation

- 80% of U&C for Phase I and Phase II, when ordered by a physician.
- Medical necessity must be determined if cardiac rehabilitation is to be considered a covered expense, and services must be provided in a medical facility approved by the Medical Plan Administrator.

Chemotherapy

- 80% of U&C when ordered by a physician.

Charges for infusion catheters to administer the drugs/agents are considered a surgical procedure and paid separately. For chemotherapy received in the home, see Home Infusion Therapy.

Chiropractic Services

- 80% of U&C.
- Eligible charges for medically necessary manipulation and therapeutic modalities for acute illness or injury are covered. Coverage ends once medical documentation indicates that maximum medical improvement has been achieved and treatment is primarily for maintenance.

Christian Science Practitioner

- 80% of charges for the services of:
  - Christian Science Practitioner (see Glossary).
  - Christian Science Nurse (see Glossary).

Circumcision

- 80% of U&C for professional services.
- Charges for circumcision are considered to be covered expenses, when billed as a separate claim for the newborn, if performed within the first thirty (30) days following birth and if the newborn is enrolled in the Plan.
- Charges for circumcision performed beyond the 30-day time frame are considered to be covered expenses only when medical necessity is documented.

Dental Services

- Accidental Injury:
  - 80% of U&C for professional services necessary as a result of an accidental injury to sound natural teeth caused by an external force. Care must be rendered within 3 months of original accidental injury. The appropriate facility benefit applies. The benefit will be limited to the most cost effective treatment available as determined by the Medical Plan Administrator.
- Inpatient Room and Board:
  - 80% of established U&C for semi-private room and board only for medically necessary hospital admissions to perform dental services (nonaccidental) only when a medical condition such as heart disease or hemophilia exists. **Professional services are not covered under the medical indemnity plan.**
- Dental exclusions include, but are not limited to:
  - Services and appliances related to the diagnosis or treatment of Temporomandibular Joint Disorder or Syndrome (TMJ) and other myofunctional disorders.
  - Internal accidental injury to the mouth caused by biting on a foreign object.
  - Outpatient services for routine dental care.

Diabetic Coverage

- For Dietitian Services and Consultation:
  - 80% of U&C when diagnosed with diabetes. No coverage unless ordered in conjunction with a diagnosis of diabetes.
- For routine foot care by a physician:
  - 80% of U&C when diagnosed with diabetes.
- For insulin pumps and related supplies:
  - 80% of U&C.

Dialysis – Hemodialysis and Peritoneal

- 80% of U&C.

Durable Medical Equipment

- Short-term Rental:
  - 80% of U&C up to the purchase price for items that temporarily assist an impaired organ or body part during recovery. Some examples are canes, crutches and walkers.
- Purchase:
  - 80% of U&C to purchase the equipment. Equipment should be purchased only if it is expected that the rental costs will exceed the purchase price.
- Durable medical equipment exclusions include, but are not limited to:
  - Repairs or replacements due to negligence or loss of the item.
  - Newer or more efficient models.
  - Items viewed as convenience items such as exercise equipment and non-hospital type adjustable beds.
  - Environmental items such as air conditioners, humidifiers, dehumidifiers or purifiers.
  - For specific equipment coverage and medical necessity requirements, contact the Medical Plan Administrator.
  - Similar or redundant equipment for patient convenience.

NOTE: See Prosthetic Appliances for permanent replacement of a body part.

Emergency Services

Emergency services are those services provided to alleviate severe pain or for immediate diagnosis and/or treatment of conditions or injuries such that in the opinion of a prudent layperson might result in permanent disability or death if not treated immedi-

ately. **The facility in which emergency treatment is rendered determines the benefit level, regardless of the type of emergency facilities available.**

- Emergency Room:
  - 80% of U&C after $250 special emergency room deductible; this deductible applies to each visit to an emergency room which does not result in an inpatient admission.
- Physician's Office:
  - 100% of U&C; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. Non-emergency medically necessary care considered at 80% of U&C.
- Urgent Care or Similar Facility:
  - 100% of U&C; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. Non-emergency medically necessary care considered at 80% of U&C (see Urgent Care Services in this section).

Family Planning

- Tubal Ligation:
  - Coverage is extended as in any other condition.
- Vasectomy:
  - Coverage is extended as in any other condition.
- Family planning exclusions include, but are not limited to:
  - Charges for services relating to the reversal of sterilization.
  - Any drug or device prescribed or used for the purpose of contraception.

Foot Orthotics

- 80% of U&C.
- Subject to medical necessity, and ordered by a physician.
- Must be custom molded or fitted to the foot.

Hearing Exams

- 80% of U&C for professional fees for the hearing exam associated with the care and treatment of an injury or an illness.
- Hearing aids and associated costs, including the exam and evaluation for the purpose of screening and obtaining a hearing aid, are not covered.

Home Health Care Services –

See Skilled Nursing Care

Home Infusion Therapy

- 80% of U&C.
- Medical necessity must be determined by the MCM Administrator in order for therapy to be considered a covered expense.
- Home infusion therapy must be under the supervision of a physician.
- Covered expenses include, but are not limited to:
  - Medication and intravenous solution.
  - Equipment rental and supplies such as infusion sets, syringes and heparin.

Hospice

- 80% of U&C. Written documentation of terminal condition (i.e., life expectancy of six months or less) is required from the attending physician.
- Must be approved by the plan administrator as meeting established standards including any legal licensing requirements.

Hospital Services

- Inpatient:
  - 80% of negotiated PPO hospital rate if using a PPO hospital.
  - 70% of U&C if residence is not within 25 miles of a TCHP PPO hospital.
  - 60% of U&C if residence is within 25 miles of a TCHP PPO hospital but plan participant elects to use a non-PPO hospital instead.
  - If residence is within 25 miles of a TCHP PPO hospital, but emergency or specialized care is required which is not available at the TCHP PPO hospital, an exception to the non-PPO rate of 60% may be requested. Upon request, the Notification Administrator will evaluate the case and, when appropriate, authorize an 70% of U&C benefit at a non-PPO hospital. Otherwise, 60% of U&C will apply if the plan participant chooses to travel more than 25 miles and a TCHP PPO hospital is available within the same travel distance.

- Inpatient hospitalization exclusions include, but are not limited to:
  - Holding charges (charges for days when the bed is not occupied by the patient).
  - Private room charges in excess of the established semi-private room and board rate, regardless of any medical necessity such as isolation.
  - Incremental nursing charges if billed separately. These charges are added to and capped at the established rate for room and board charges.
  - Personal convenience items such as guest meals, television rental, admission kits and telephone charges.
  - Services not related to or necessary for the care and treatment of an illness or injury.

- Outpatient:
  - Surgery
    - 80% of negotiated PPO hospital rate if performed at a PPO hospital.
    - 70% of U&C if performed at a non-PPO hospital, if an exception to non-PPO benefits is granted by the Notification Administrator.
    - 60% of U&C if performed at a non-PPO hospital.
    - 80% of U&C if performed at an ambulatory surgical treatment center which is licensed by the Illinois Department of Public Health, or the equivalent agency in other states, to perform outpatient surgery.
    - **Surgical facility exclusions include, but are not limited to:**

      Facility charges for a surgery performed in or billed by a physician's office or clinic; unless specific state ambulatory surgical treatment center licensing requirements are met.

      Facility charges for a surgery or procedure which is not covered.
  - Other services such as non-emergency services:
    - 80% of negotiated PPO hospital rate if performed at a PPO hospital. The plan participant's coinsurance applies to the general out-of-pocket maximum.
    - 70% of U&C if the plan participant's residence is not within 25 miles of a TCHP PPO hospital. The plan participant's coinsurance applies to the general out-of-pocket maximum.
    - 60% of U&C if the plan participant's residence is within 25 miles of a TCHP PPO hospital and participant elects to use a non-PPO hospital. The plan participant's coinsurance applies to the non-PPO out-of-pocket maximum.

NOTE: Failure to provide appropriate notification will result in a $1,000 penalty and no coverage for services not deemed to be medically necessary. See Notification Requirements in Chapter 2, Section entitled TCHP General Information.

Infertility Treatment

Benefits are provided for the diagnosis and treatment of infertility. **Infertility is defined as the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.**

- Pre-determination of Benefits:
  - A written pre-determination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment to ensure maximum benefits. Documentation required from the physician includes the patient's reproductive history including test results, information pertaining to conservative attempts to achieve pregnancy, and the proposed plan of treatment with CPT codes.
- Infertility Benefits:
  - Coverage is provided only if the plan participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this Plan.
  - Coverage for Assisted Reproductive Procedures include, but are not limited to:
    - Artificial Insemination, Invitro Fertilization (IVF) and similar procedures which include but are not limited to: Gamete Intrafallopian Tube Transfer (GIFT), Low Tube Ovum Transfer (TET) and Uterine Embryo Lavage.

- A maximum of three (3) artificial insemination procedures per menstrual cycle for a total of eight (8) cycles per lifetime.
- A maximum of four (4) procedures per lifetime for any of the following:
  - Invitro Fertilization, Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intrafallopian Tube Transfer (ZIFT) and other similar procedures.
- Eligible medical costs associated with sperm or egg donation by a person covered under the Plan may include, but are not limited to:
  - Monitoring the cycle of a donor, and retrieval of an egg for the purpose of donating to a covered individual.

- Benefit Level:
  - The appropriate benefit level will apply (i.e., physician charges are covered at 80% of eligible charges; lab and x-ray are covered at 80% of eligible charges).
- Infertility treatment exclusions include, but are not limited to:
  - Medical or non-medical costs of anyone not covered under the Plan.
  - Non-medical expenses of a sperm or egg donor covered under the Plan including, but not limited to:
    - Transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling a donor, cost of sperm or egg purchased from a donor bank, cryo-preservation and storage of sperm or embryo, or fees payable to a donor.
  - Infertility treatment deemed experimental in nature.
  - Persons who previously had a voluntary sterilization or persons who are unable to achieve pregnancy after a reversal of a voluntary sterilization.
  - Payment for medical services rendered to a surrogate for purposes of attempting or achieving pregnancy. This exclusion applies whether the surrogate is a plan participant or not.
  - Pre-implantation genetic testing.

Lab and X-ray

- Outpatient:
  - 80% of U&C at a physician's office, hospital, clinic or urgent care center.
- Inpatient:
  - If billed by a hospital as part of a hospital confinement, paid at the appropriate hospital benefit level.

Medical Supplies

- 80% of U&C.
- Medical supplies include, but are not limited to:
  - Ostomy supplies, surgical dressings and surgical stockings.

NOTE: This covers a wide range of supplies for all types of medical conditions. However, the requirement for any supply is that it must have a primary medical purpose.

- Medical supply exclusions include, but are not limited to:
  - Personal convenience items, such as diapers.
  - Supplies that are not medically necessary for the diagnosed illness or injury.
  - Appliances for temporomandibular joint disorder or syndrome (TMJ), myofunctional disorders or other orthodontic therapy.

Newborn Care

- 80% of U&C for professional visits in the hospital:
  - Facility charges paid at appropriate benefit level, see Inpatient Hospitalization.
- Benefits are available for newborn care only if the dependent is enrolled no later than 31 days following the birth.

Nurse Practitioner

- 80% of U&C for professional services provided under the supervision of a physician and billed by a physician, hospital, clinic or home health care agency.

Occupational Therapy/Physical Therapy

- 80% of U&C, if administered under the supervision of and billed by a licensed or registered occupational therapist, physical therapist or physician.
- Eligible charges for medically necessary therapeutic modalities for acute illness or injury are covered. Coverage ends once medical documen-

tation indicates the maximum medical improvement has been achieved and treatment is primarily for maintenance.

- Occupational therapy/physical therapy exclusions include, but are not limited to:
  - Therapy as part of an educational program and considered to be education and/or training.
  - Therapy when improvement is no longer documented.

Physician Services

Effective July 1, 2002, the plan covers 90% of the negotiated fee after the annual plan deductible if utilizing a participating physician in the CIGNA Healthcare PPO Physician Network. U&C does not apply.

- 80% of U&C for non-network providers for medical treatment of an injury or illness.
- Physician charges associated with services not eligible for coverage under the Plan are excluded.
- Inpatient Surgery:
  - Follow-up care by the surgeon is considered part of the cost of the surgical procedure. It is not covered as a separate charge.
- Outpatient Surgery:
  - If surgery is performed in a physician's office, the following will be considered as part of the fee:
    - Surgical tray and supplies.
    - Local anesthesia administered by the physician.
    - Medically necessary follow-up visits.
- Plastic Surgery is limited to the following:
  - An accidental injury.
  - Congenital deformities that are evident in infancy.
  - Reconstructive mammoplasty following a mastectomy when medically indicated.
- Assistant surgeon:
  - A payable assistant surgeon is a physician who assists the surgeon subject to medical necessity.
  - Up to 20% of U&C of eligible charges.
- Multiple procedures:
  - Standard guidelines are used in processing claims when multiple surgical procedures are performed during the same operative session.
  - Benefits will be paid for the most inclusive (comprehensive) procedure. Additional procedures are paid at a lesser level. Contact the Medical Plan Administrator for a pre-determination of benefits.
- Surgical exclusions include, but are not limited to:
  - Abortion, induced miscarriage or induced premature birth, unless it is a physician's opinion that such procedures are necessary to preserve the life of the mother, or an induced premature birth is intended to produce a live, viable child and is necessary for the health of the mother or her unborn child.
  - Keratotomy or other refractive surgeries.
  - Obesity surgery unless medically necessary to treat morbid obesity (two times normal body weight).
  - Surgery not recommended, approved and performed by a physician.

Podiatry Services

- 80% of U&C for medically necessary podiatric treatment and surgeries.
- Routine foot care is covered only with the diagnosis of diabetes.

Prescription Drugs

- 80% of U&C if the drug is billed by a physician's office and not obtained at a pharmacy.
- Prescription drugs obtained as part of a hospital stay, skilled nursing facility, extended care facility or a nursing home are payable at the appropriate facility benefit level.
- If purchased at a pharmacy, the Prescription Drug Plan benefits apply.

See Chapter 2, Section entitled Prescription Drug Plan.

Prosthetic Appliances

A prosthetic appliance is one which replaces a body part. Examples are artificial limbs and artificial eyes.

- 80% of U&C for:
  - The original prosthetic appliance.
  - Replacement of a prosthetic appliance due to growth or a change in the person's medical condition.

- Repair of a prosthetic appliance due to normal wear and usage and no longer functional.

- No payment will be made if the appliance is damaged or lost due to negligence.
- Prosthetic appliances exclusions include, but are not limited to:
  - Appliances not recommended or approved by a physician.
  - Appliances to overcome sexual dysfunction, except when the dysfunction is related to an injury or illness.
  - Items considered to be cosmetic in nature such as artificial fingernails, toenails, eyelashes, wigs, toupees or breast implants.
  - Experimental or investigational appliances.
  - Hearing aids or dentures.

Radiation Therapy

- 80% of U&C for radiation therapy ordered by a physician in an outpatient setting.
- Appropriate facility benefit for inpatient stays.

Second Surgical Opinion

The Notification Administrator will determine the necessity of obtaining a second opinion for both inpatient and outpatient procedures.

- 100% of U&C if required by Notification Administrator. No plan year deductible applies.
  - Contact the Notification Administrator who will determine if a second opinion for a surgical procedure is required.
  - Failure to obtain a second opinion when required and proceeding with the surgery will result in a $1000 penalty.
- 80% of U&C (if not required by the Notification Administrator). Plan year deductible applies.

Skilled Nursing –
In a Home Setting

- Contact the MCM Administrator for a determination of maximum benefits.
- 80% of eligible charges.
- The benefit for skilled nursing care will be limited to the lesser of the cost for care in a home setting or the average cost in a skilled nursing facility, extended care facility or nursing home.
- The continued coverage for skilled nursing care will be determined by the review of medical records and nursing notes.

Skilled Nursing –
In a Skilled Nursing Facility, Extended Care Facility or Nursing Home

- Must be a licensed healthcare facility primarily engaged in providing skilled care.
- Notification is required at least 7 days prior to admission or at time of transfer from an inpatient hospital stay.
- 80% of U&C for eligible charges.
- The service must be medically necessary and ordered by a physician.
- The continued coverage for skilled nursing care will be determined by the review of medical records and nursing notes.
- Holding charges (charges for days when the bed is not occupied by the patient) are not covered.
- Benefits are available up to 100 days each plan year. Benefits cease after the 100th day.

NOTE: Extended care facilities are sometimes referred to as nursing homes. Most care in nursing homes is NOT skilled care and therefore is NOT covered. Many people purchase long-term care insurance policies to cover those nursing home services which are NOT covered by medical insurance or Medicare.

Speech Therapy

- 80% of U&C for medically necessary speech therapy ordered by a physician.
- Treatment must be for a speech disorder resulting from injury or illness serious enough to significantly interfere with the ability to communicate at the appropriate age level.
- The therapy must be restorative in nature; with the ability to improve communication.
- The person must have the potential for communication.

Transplant - Organ and Tissue

(Notification Required)

TCHP includes a Transplant Preferred Provider Organization (TPPO) hospital network. **For organ or bone marrow transplants to be covered under the Plan, one of the designated organ-specific TPPO hospitals must be utilized.** The network is subject to change. Call the Notification Administrator for information on current TPPOs.

- The transplant process has three phases:

1. **Pre-transplant Evaluation Phase:**

   All diagnostic treatment rendered to determine if a plan participant may be a candidate for a transplant is paid at normal plan benefits.

   The transplant candidate must contact the Notification Administrator of the potential transplant. Once notification occurs, the Medical Case Management (MCM) Administrator will coordinate all additional treatments and services. Benefits are limited to services approved by the Notification Administrator. There may be no benefits available for charges related to listing with multiple hospitals, duplicate or repetitive services.

   This phase consists of transplant-related services necessary to assess and evaluate the transplant candidate. If the transplant candidate receives services during this phase in a TPPO, benefits are payable at 80% of the contracted rate.

2. **Transplantation and Hospitalization Phase:**

   This phase begins on the first day of the transplant inpatient stay and continues through the day of discharge. For transplants performed in an outpatient setting this phase begins on the date of the transplant procedure. Benefits are paid at 80% after a $100 transplant deductible.

3. **Post-Transplant Phase:**

   This phase begins immediately following inpatient or outpatient discharge and continues for 12 months. All charges submitted by the TPPO are covered at 80% of the contracted rate. All other services are subject to normal plan provisions.

- Benefits are available for the following transplants:
  - Bone Marrow (autologous or allogenic)
  - Heart
  - Heart/Lung
  - Kidney
  - Kidney/Pancreas
  - Liver
  - Lung
  - Pancreas

In some cases, transplants may be considered non-viable for some candidates, as determined by the Notification Administrator in coordination with the transplant hospital.

- Transplant exclusions include, but are not limited to:
  - Investigational drugs or experimental procedures.
  - Charges related to the search for an unrelated bone marrow donor.
  - Corneal transplants.

NOTE: If a physician determines that a plan participant is being considered for a transplant, the Notification Administrator must be contacted within two business days. The Notification Administrator will assist in maximizing benefits and ensuring services are covered.

Coordination of Benefits

- When both donor and recipient are covered under the Plan, both are entitled to benefits under the Plan, under separate claims.
- When only the recipient is covered, the donor's charges are covered as part of the recipient's claim, if the donor does not have insurance coverage, or if the donor's insurance denies coverage for medical expenses incurred.
- When only the recipient is covered by the Plan, and the donor's insurance provides coverage, the Plan will coordinate with the donor's plan.
- When only the donor is covered, only the donor's charges will be covered under the Plan.

Transportation and Lodging Benefit

- The Plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those plan participants who have been accepted as a candidate for transplant services in a program.
  - The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals.

Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to:

CMS/Group Insurance Division
Attn: Organ Transplant Reimbursement
Room 600, Stratton Office Building
Springfield, IL 62706

Urgent Care Services

Urgent Care is care for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a physician's office, urgent care facility or prompt care facility. Medically necessary emergency care is considered at 100% of U&C (see Emergency Services in this section).

- 80% of U&C for non-emergency care.

NOTE: See Emergency Services for medically necessary emergency care.

For information regarding these or other covered benefits contact the Medical Plan Administrator.